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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G119	A. BUILDING _____ B. WING _____	C 01/16/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ID1	4515 EDSON PLACE, NE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS The Health Regulation Licensing Administration (HRLA) received a complaint via e-mail on January 15, 2007 at approximately 6:16 PM from the Department of Disability Services (DDS). The complaint indicated that that Client #1 ' s health and safety were at risk due to following: a) Improper physician documentation; b) Lack of transcription of Physical Therapy orders; c) Probable inadequate medical orders to treat ulcers; Due to the nature of this complaint, an investigation was initiated on January 16, 2008. The findings of the investigation were based on client observations, and staff interviews, and review of client and administrative records; including incident reports. As a result of the findings, a determination was made that the facility failed to comply with federal requirements in the Conditions of Governing Body and Management, and Health Care Services.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, staff interviews, and record reviews the governing body failed to have a policy to ensure that physician's telephone orders were signed within 24 hours as required by local regulation [Title 7, Subtitle D, Chapter 13]; to ensure that nurses were adequately trained and	W 104	W104 This Standard will be met as evidenced by: Governing body will amend current policy to ensure that physician's telephone	

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HEALTH REGULATION
ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

DKB — 2/25/08

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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W 104	Continued From page 1 practiced standard level of care. The findings include: 1. Review of the physician's orders sheet (POS) on January 16, 2008 at approximately 8:10 AM revealed that Client #1 had several telephone orders that had not been signed by the facility's Primary Care Physician (PCP) within twenty- four (24) hours as documented below: a. January 7, 2008: -Primidone 250 mg one tablet via gastric tube every eight hours; - Keppra 750 mg one tablet via gastric tube every twelve hours; -Iron Sulfate 325 mg tablet twice a day via gastric tube; - Catapres 0.3 mg one tablet via gastric tube twice a day (hold for systolic pressure of less 110); -Colace liquid 25mg (100ml.) via gastric tube twice a day; -Mupirocin ointment 2% twice a day apply to lesions; -Lasix solution 4 ml. (40mg) via gastric tube daily; -Muliti-vitamin tablet one via gastric tube; -Tylenol solution 20.3 ml (650 mg) via gastric tube every six hours PRN	W 104	W104, continued - - - orders are signed within 24 hours 1. a, b & c All telephone orders dated 1/7/08 were signed by the PCP. Future telephone orders will be faxed to the PCP upon receipt of the orders for review and signature. The PCP will fax the signed telephone orders back to the facility for filing in the clients' records. This process will ensure that telephone orders are signed by the PCP within 24 hours of order. In addition the RN Supervisor will conduct regular oversight and record reviews	2/15/08 & Ongoing

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W 104	Continued From page 2 (when ever necessary); and - Fleets enema one rectally PRN if no bowel movement in two days. b. January 9, 2008: - Discontinue Multi-vitamin tablet one via gastric tube and start Stress formula with Zinc one tablet via gastric tube ; c. January 14, 2008: - Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar; and -Curasol gel to all healthy tissue to promote healing. The Licensed Practical Nurse (LPN) on January 16, 2008 at approximately 10:00 AM acknowledged that the PCP had not signed verbal telephone orders with-in twenty- four (24) hours on January 7, 2008, January 9, 2008 and January 14, 2008. 2. The facility failed to have a policy to ensure that nurses were adequately trained and practiced standard level of care as evidenced below: a [Cross Refer to 339.2] The facility failed to ensure adequate training for nursing staff to only transcribed dietary orders that were prescribed by the PCP for Client #1 on the MAR. b [Cross Refer to 339.3] The facility failed to ensure adequate training for nursing staff to document on the MAR according to the Principles	W 104	2. a. Reference response to W 339.2 b. No deficiency cited W 339.3 on the deficiency report.	

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W 104	Continued From page 3 of Nursing Documentation for Client #1. c [Cross Refer to W368] The facility failed to ensure adequate training for nursing staff to ensure that medications were given in compliance with the PCP's orders for Client #1.	W 104	c. Reference response to W 368	
W 114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that entries onto a client ' s Medication Administration Records were signed for one of one client investigated. (Client #2) The finding includes: Review of the MAR dated January, 2008 on January 15, 2008 at approximately 9:25 AM revealed that documentation was crossed out without being initialed on the MAR as evidenced by: a. An entry on August 10, 2007 for the administration of 150 ml. of water every six hours via gastric tube was crossed out and dated January 7, 2008, indicating that the order had been discontinued. There was no indication as to the staff person who made the deletion on the MAR. b. An entry on August 10, 2007 for the administration of Keppra 750 mg twice daily via gastric tube was crossed out and dated January 7, 2008, indicating that the order had been discontinued. There was no indication as to the	W 114	W114 This Standard will be met as evidenced by: RN will provide appropriate follow-up to include disciplinary action for failure to ensure entry onto client's MAR. RN continues to provide training and monitoring in this area. a, b, c, d & e A training for the nursing staff is scheduled for 2/28/08 to address acceptable practice when deleting or discontinuing medications on the records. This will include appropriate initial/signature to identify the writer & reason for deletion. In addition the RN Supervisor will conduct regular oversight & record reviews.	2/28/08 & Ongoing

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W 114	Continued From page 4 staff person who made the deletion on the MAR. d. An entry on August 10, 2007 for the administration of Primidone 250 mg three times a day via gastric tube was crossed out and dated January 7, 2008, indicating that the order had been discontinued. There was no indication as to the staff person who made the deletion on the MAR. e. An entry on August 10, 2007 for the administration of Iron Sulfate 325 mg tablet twice a daily for nutritional supplement via gastric tube was crossed out and dated January 7, 2008, indicating that the order had been discontinued. There was no indication as to the staff person who made the deletion on the MAR. In an interview with the LPN on January 16, 2008 at approximately 9:26 AM it was acknowledged that the nursing staff crossed out documentation without initialing the entries according to the Principles of Nursing Documentation. There was no documented evidence that the nursing staff documented on the MAR according to the Principles of Nursing Documentation.	W 114		
W 159	[This is a repeat deficiency. Please refer to federal deficiency report, dated 10/05/07] 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.	W 159	W159 This Standard will be met as evidenced by:	

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W 159	Continued From page 5 This STANDARD is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for one of one client in the investigation. (Client #1) The finding includes: 1. Cross Refer to W322.1. The QMRP failed to coordinate services with the Interdisciplinary Team (IDT) to ensure that Client # 1's Health Management Care Plan's (HMCP) recommendation to obtain a pressure mattress was addressed. 2. On January 16, 2008, at approximately 7:40 AM Client #1 was observed lying in bed on his left side. The bed did not have a pressure mattress. The facility's Licensed Practical Nurse (LPN) was interviewed on January 16, 2008 at approximately 8:10 AM and acknowledged that Client #1 did not have a pressure mattress on his bed. Review of Client #1's HMCP updated on January 7, 2008, on January 16, 2008, at approximately 8:00AM recommended a pressure mattress for the client's bed to assist in preserving skin integrity. Review of the nursing progress notes dated January 7, 2008, on January 16, 2008 at approximately 8:15 AM revealed Client #1 had multiple Stage I to Stage II decubitus ulcers on his hips, bi-laterally right wrist, back, left foot, left heel, left buttocks and left knee. There was no evidence that the client had a pressure mattress on his bed as recommended by the HMCP.	W 159	W159... 1 & 2. Client # 1 had a pressure mattress (egg crate mattress) on his bed since he came to the facility in March 2007. He received the alternating pressure mattress on 1/22/08. All the pressure sores are completely healed except for the lesion on the anterior right wrist which is healing. The area has 2 scab formations of 0.5cm each. (See attachment # 1)	2/16/08 and Ongoing
W 322	483.460(a)(3) PHYSICIAN SERVICES	W 322	W322	

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W 322	Continued From page 6 The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility's failed to directly assess Client #1 upon re-admission to the facility from a hospital stay; failed to address recommendations made by the medical consultants for Client #1; and failed to specify the specific pressure areas for the application of the hydrocolloid wound dressing; and failed to specify the specific healthy tissue site(s) for the application of the curasol gel treatment for one of one client in the investigation. (Client #1) The findings include: Client #1 was admitted to a local hospital on December 12, 2007 with admitting diagnoses of seizure disorder and urinary tract infection (UTI). The client was discharged on January 7, 2008 with diagnoses of seizure disorder, Urinary Tract Infection (UTI), anemia, Bullous disease, and alterations in fluids, electrolytes and nutrition. The physician failed reassess the client as his return to the facility and to verify the implementation of re-admission orders as evidenced by the following: a) Interview with the Licensed Practical Nurse (LPN) on January 16, 2008 at approximately 8:50 AM revealed that the Primary Care Physician (PCP) was the client's attending physician while he was hospitalized. The LPN stated that the PCP had visited the facility during the weekend (January 12-13, 2008); however, there was no	W 322	This Standard will be met as evidenced by: a. Since the PCP was the attending physician during the client's hospitalization the PCP gave telephone admission orders upon the client's return to the facility. The client was visited by the PCP on 1/19, 2/9 & 2/16/08 since then as evidenced by the documentation of these visits in the client's record. The nursing staff will ensure that the PCP will assess the client upon readmission from hospitalization.	2/19/08 and Ongoing

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W 322	Continued From page 7 evidence that the PCP assessed the client. b) On January 16, 2008 between 8:10 AM and 9:18 AM Client #1's medical and clinical records were reviewed. The records revealed telephone admission orders, dated January 7, 2008. The telephone orders prescribed Resource 2.0 (one can daily at 7:00 AM, 11:00 AM, 4:00 PM and 8:00 PM). The records also revealed a "Nutritional Re-admission Evaluation" dated January 8, 2008. The evaluation recommended that Client #1's gastric tube feedings be increased to Resource 2.0, five cans daily at 7:00 AM, 11:00 AM, 4:00 PM, 8:00 PM and 12:00 midnight. Transcribed on the client's Medication Administration Record (MAR) was Resource 2.0 (five cans daily at 7:00 AM, 11:00 AM, 4:00 PM, 8:00 PM and 12:00 midnight). There was no documented evidence that the PCP addressed the nutritionist's recommendation that Client #1's gastric tube feedings be increased to Resource 2.0, five cans daily at 7:00 AM, 11:00 AM, 4:00 PM, 8:00 PM and 12:00 midnight. c) On January 16, 2008 between 8:11 AM and 9:21 AM Client #1's medical and clinical records were reviewed. The records revealed telephone admission orders, dated January 7, 2008. The telephone orders included an order to flush gastric tube with 30-60 ml. of water before and after each medication pass. Review of the Nutritional Readmission Evaluation dated January 8, 2008 revealed a recommendation to increase water flushes to 200cc after each feeding. The client's MAR indicated that the nurse started flushing the gastric tube with 200cc of water on January 9, 2008 at 4:00.	W 322	b, c & d. The PCP was notified of the Nutritionist recommendations dated 1/8/08 on 1/9/08. These recommendations were received by the nurse on 1/9/08. The PCP approved the recommendations and gave the telephone orders on 1/9/08. These orders were written and transcribed onto the MAR on 1/9/08. (See attachment # 2)	1/9/08 and Ongoing

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W 322	Continued From page 8 d) On January 16, 2008 between 8:11 AM and 9:23 AM Client #1's medical and clinical records were reviewed. The records revealed telephone admission orders, dated January 7, 2008. The telephone orders prescribed Prosource 30 ml (daily mixed with 30 ml of water via gastric tube). Review of the Nutritional Readmission Evaluation dated January 8, 2008 revealed a recommendation for one scoop of Prosource Protein Powder three times a day, mixed with 30 ml of water via gastric tube. The client's January 9, 2008 MAR indicated that the nurse started administering one scoop of Prosource Protein Powder three times a day instead of once a day as ordered by the physician. e) Review of Client#1's hospital Discharge Summary dated January 7, 2008 on January 16, 2008 at approximately 8:12 AM revealed that Client #1's discharge medications included Lovenox 40 mg subcutaneously every day. This medication was used as a prophylaxis while in the hospital. f) Review of the LPN's nursing notes, dated January 7, 2007 at 4:00 PM revealed the following description of Client #1's pressure ulcers; Two Stage II pressure areas on the right hip measuring 3 x 4 cm; Stage II pressure areas bi-laterally on the right wrist spreading up the arm towards the elbow measuring 3 x 4 cm on the inner aspect of the wrist and 11 x 3 cm on the outer aspect of the wrist; Stage I pressure area on the left hip;	W 322	e. The PCP did not order the Lovenox as a part of the readmission orders. He claimed the client did not need it at the facility since he was being repositioned and gotten out of bed frequently. f. The nurses will be re-trained on clarifying unclear orders or directives on 2/28/08. In addition the nurses will be trained on a new form developed to be utilized when receiving telephone orders. (See attachment # 3) RN will continue to monito and provide direction as needed for LPN staff to further ensure compliance	2/13/08 2/28/08 & Ongoing

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W 322	Continued From page 9 Five Stage I pressure areas on the left side of the back measuring 2 x 2 cm; Stage II pressure areas on the left side of left foot near the little toe measuring 2 x 2 cm; Stage I and Stage II pressure areas on the left heel; Stage I pressure on left knee; Stage I pressure ulcer on left buttocks and Stage I pressure area on the left hip. Review of the physician's re-admission telephone orders dated January 7, 2008, on January 16, 2008 at approximately 8:15 AM revealed that Client #1 had an order for "hydrocolloid wound dressing over pressure areas". Further review revealed that the dressing was to be changed every three days and PRN (when ever necessary). The facility's Licensed Practical Nurse (LPN), interviewed on January 16, 2008 at approximately 8:30 AM, acknowledged that primary care physician did not specify the specific pressure areas for the application of the hydrocolloid wound dressing treatment in his telephone order. Additional the nurse failed to clarify the order. Review of the physician's telephone orders dated January 14, 2008, on January 16, 2008 at approximately 8:07 AM revealed that Client #1 had an order for "curasol gel to all healthy tissue to promote healing". In an interview with the LPN on January 16, 2008 at approximately 8:40 AM it was acknowledged that Client #1's physician's	W 322	W322. . . With this standard	

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W 322	Continued From page 10 telephone orders did not specify the specific healthy tissue site (s) to apply the curasol gel treatment There was no evidence that the physician's telephone orders specified the specific healthy tissue site (s) for the application of the curasol gel treatment. Additional the nurse failed to clarify the order.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure nursing services in accordance with the needs of one of one client in the investigation. (Client #1) The findings include: 1. Cross Refer to W339.1 The facility's nursing staff failed to transcribe a medication order on the Medication Administration Record (MAR) prescribed by the PCP for Client #1. 2.Cross Refer to W368. The facility's nursing staff failed to ensure that medications were given in compliance with the physician's orders for Client #1. 3. Cross Refer to W322.1. The facility's nursing staff failed to clarify the physician's orders for the application of the hydrocolloid wound dressing treatment to Client 1's pressure areas. 4. Cross Refer to W322.2. The facility's nursing staff failed to clarify the physician's orders for the application of the curasol gel treatment to Client	W 331	W331 This Standard will be met as evidenced by: 1. Reference response to W 339.1 2. Reference response to W 368 3. Reference response to W 322 F 4. Reference response to W 322 F	

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W 331	Continued From page 11 1's healthy tissue site (s). 5. Cross Refer to 339.2. The facility's nursing staff transcribed dietary orders on the MAR that were not prescribed by the PCP for Client #1. [This is a repeat deficiency. Please refer to federal deficiency report, dated 10/05/07]	W 331		
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on interview and record review, the Licensed Practical Nurse (LPN)to ensure that physician's orders were followed for one of one client investigated. (Client #1) The findings include: 1. The facility's nursing staff failed to transcribe a medication order on the MAR for Client #1 as prescribed by the PCP as evidenced by: Review of the nursing progress notes dated January 7, 2008, on January 16, 2008 at approximately 8:15 AM revealed that Client #1 had Stage II pressure areas bi-laterally on the right wrist spreading up the arm towards the elbow measuring 3 x 4 cm on the inner aspect of the wrist and measuring 11 x 3 cm on the outer aspect of the wrist. Review of the physician's telephone order dated January 14, 2008 revealed that Client #1 was prescribed "Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar". [See W322]	W 339	W339 This Standard will be met as evidenced by: 1. The nursing staff will be re-trained on administering treatment according to the physician's order/instruction. In addition, nurses will clarify orders with the PCP if instructions are unclear. Additionally the RN Supervisor will conduct regular record reviews. Reference response to W 322.	2/28/08 & Ongoing

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 339	Continued From page 12 2. [Cross Reference W322] The facility's nursing staff transcribed on Client #1's MAR and implemented dietary recommendations from the nutritionist that were not prescribed by the PCP.	W 339	2. Reference response to W 322 b, c & d	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that medications were given in compliance with the physician's orders for one of one client in the investigation. (Client #1) The finding includes: On January 16, 2008 Client #1 was observed in his bed lying on his left side. The client's right right forearm was observed with multiple healing areas. Review of the nursing progress notes dated January 7, 2008 revealed that Client #1 had Stage II pressure areas bi-laterally on the right wrist spreading up the arm towards the elbow measuring 3 x 4 cm on the inner aspect of the wrist and 11 x 3 cm on the outer aspect of the wrist. Review of the physician's telephone order dated January 14, 2008 on January 16, 2008 at approximately 8:10 AM revealed that Client #1 was prescribed "Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar". In an interview with the Licensed Practical Nurse (LPN) on January 16, 2008 at	W 368	W368 This Standard will be met as evidenced by: RN will address LPN staff who failed to administer medications in compliance with physician's orders. The nursing staff will be retrained on 2/28/08 on transcribing orders of medication and or treatment onto the MAR as soon as the order is received. The treatment was transcribed onto the MAR on 1/16/08 and was initiated on 1/16/08 when the medication became available. In addition the RN Supervisor will conduct regular oversight and record review. (See attachment #4)	2/28/08 & Ongoing

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W 368	Continued From page 13 approximately 8:55 AM it was acknowledged that "Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar " was not transcribed on Client#1's January, MAR and that the client had not received the medication. Review of the January, MAR on January 16, 2008 at approximately 9:00 AM revealed no documented evidence that Client #1 had received Accuzyme ointment to his necrotic wound on right forearm and wrist in compliance with the physician's orders.	W 368		

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I 000	INITIAL COMMENTS Surveyor: 19076 The Health Regulation Licensing Administration (HRLA) received a complaint via e-mail on January 15, 2007 at approximately 6:16 PM from the Department of Disability Services (DDS). The complaint indicated that that Client #1 ' s health and safety were at risk due to following: a) Improper physician documentation; b) Lack of transcription of Physical Therapy; c) Probable inadequate medical orders to treat ulcers; Due to the nature of this complaint, an investigation was initiated on January 7, 2008. The findings of the investigation were based on client observations staff and consultant interviews, and review of client and administrative records; including incident reports.	I 000		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Surveyor: 19076 Based on observation, interview and record review, the GHMRP failed to ensure adequate administrative support had been provided to efficiently meet the needs for one of one resident in the investigation as required by their habilitation plans. (Resident # 1) The findings include:	I 180	3508.1 This Statute will be met as evidenced by:	2.16.08 ongoing

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I 180	Continued From page 1 The facility's governing body failed to have a policy to ensure that physician's telephone orders were signed within 24 hours as required by local regulation [Title 7, Subtitle D, Chapter 13] as evidenced by the following: 1. Review of the physician's orders sheet (POS) on January 16, 2008 at approximately 8:10 AM revealed that Client #1 had several telephone orders that had not been signed by the facility's Primary Care Physician (PCP) with-in twenty- four (24) hours as documented below: a. January 7, 2008: -Primidone 250 mg one tablet via gastric tube every eight hours; - Keppra 750 mg one tablet via gastric tube every twelve hours; -Iron Sulfate 325 mg tablet twice a day via gastric tube; - Catapres 0.3 mg one tablet via gastric tube twice a day (hold for systolic pressure of less 110); -Colace liquid 25mg (100ml.) via gastric tube twice a day; -Mupirocin ointment 2% twice a day apply to lesions; -Lasix solution 4 ml. (40mg) via gastric tube daily; -Muliti-vitamin tablet one via gastric tube;	I 180	1. a, b & c Reference response to W 1004	2.15.08 ongoing

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I 180	Continued From page 2 -Tylenol solution 20.3 ml (650 mg) via gastric tube every six hours PRN (when ever necessary); and - Fleets enema one rectally PRN if no bowel movement in two days. b. January 9, 2008: - Discontinue Muliti-vitamin tablet one via gastric tube and start Stress formula with Zinc one tablet via gastric tube ; c. January 14, 2008: - Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar; and -Curasol gel to all healthy tissue to promote healing. The Licensed Practical Nurse (LPN) on January 16, 2008 at approximately 10:00 AM acknowledged that the PCP had not signed verbal telephone orders with-in twenty- four (24) hours on January 7, 2008, January 9, 2008 and January 14, 2008. 2. Cross Refer to W159. The governing body's Qualified Mental Retardation Professional (QMRP) failed to ensure the coordination of services for Resident #1. 3. Cross Refer to W 322. The governing body failed to ensure that the facility's medical services were provided in accordance with the needs of Resident #1. 4. Cross Refer to W331. The governing body	I 180	2. Reference response to W 159 3. Reference response to W 322 4. Reference response to W 331	2-26-08 ongoing

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I 180	Continued From page 3 failed to ensure that the facility's nursing staff provided nursing services in accordance with the needs of Resident #1. 5. Cross Refer to W339. The governing body failed to ensure that the facility's nursing services included other nursing care as prescribed by the physician for Resident #1. 6. Cross Refer to W368. The governing body failed to ensure that the facility's nursing staff administered medications in compliance with the physician's orders for Resident #1.	I 180	5. Reference response to W 339 6. Reference response to W 368	
I 230	3510.5(g) STAFF TRAINING Each training program shall include, but not be limited to, the following: (g) Habilitation planning and implementation; This Statute is not met as evidenced by: Surveyor: 19076 The findings include: 1. Review of the physician's re-admission telephone orders dated January 7, 2008, on January 16, 2008 at approximately 9:05 AM revealed that Resident #1 had an order to be weighed weekly. The facility's nutritionist's assessment indicated that the resident had sustained a significant weight loss and recommended weekly weights. The assessment revealed that the resident's Healthy Body Weight (HBW) was 118-156 pounds, however since November 2007 there had been a 22 pound weight loss (110.9 lbs on January 7, 2008, 118.4 lbs in December, 2007 and 132 pounds in November 2007). Review of the Weight/Blood	I 230	STAFF TRAINING This Statute will be met as evidenced by: 1. Weekly weights were taken and documented on the weekly weight chart located in the MAR. Weights were taken on 1/7, 1/12, 1/19, 1/26, 2/2, 2/9, 2/16 respectively. The weight loss was due to 2 recent hospitalizations and surgery since 11/07. His current weight as of 2/16/08 is 112.2 lbs. The nutritionist, nursing and medical staff continue to monitor his weight weekly.	1/12/08 and Ongoing

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I 230	Continued From page 4 Pressure Record dated January 7, 2008, on January 16, 2008 at approximately 9:12 AM revealed that Resident #1's last documented weight was 110.9 pounds on January 7, 2008. The facility's Licensed Practical Nurse (LPN), interviewed on January 16, 2008 at approximately 9:20 AM, acknowledged that Resident # 1 had not been weighed since January 7, 2008. There was no documented evidence that the resident was weighed weekly as recommended by the Primary Care Physician (PCP) and Nutritionist. 2. Cross Refer to W339.1 The facility failed to ensure adequate training for the nursing staff on transcribing medication orders on the Medication Administration Record (MAR) as prescribed by the PCP for Resident #1. 3. Cross Refer to 339.2. The facility failed to ensure adequate training for the nursing staff to only transcribe orders that were prescribed by the PCP for Resident #1 on the MAR. 4. Cross Refer to 339.3. The facility failed to ensure adequate training for the nursing staff to document on the MAR according to the Priniciples of Nursing Documentation for Resident #1. 5.Cross Refer to W368. The facility failed to ensure adequate training for nursing staff to ensure that medications were given in compliance with the PCP's orders for Resident #1.	I 230	2. Reference response to W 339.1 3. Reference response to W 339.2 4. Reference response to W 322 5. Reference response to W 368	2.28.08 ongoing
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of	I 401		

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I 401	Continued From page 5 developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Surveyor: 19076 Based on observation, interview and record review the facility's failed to directly assess Resident #1 upon re-admission to the facility from a hospital stay; failed to address recommendations made by the medical consultants for Resident #1; and failed to specify the specific pressure areas for the application of the hydrocolloid wound dressing; and failed to specify the specific healthy tissue site(s) for the application of the curasol gel treatment for one of one resident in the investigation. (Resident #1) The findings include: Resident #1 was admitted to a local hospital on December 12, 2007 with admitting diagnoses of seizure disorder and urinary tract infection (UTI). The resident was discharged on January 7, 2008 with diagnoses of seizure disorder, Urinary Tract Infection (UTI), anemia, Bullous disease, and alterations in fluids, electrolytes and nutrition. The physician failed to ensure that Resident #1 received appropriate quality care after his return from the hospital as evidenced by the following: a) Interview with the Licensed Practical Nurse (LPN) on January 16, 2008 at approximately 8:50 AM revealed that the Primary Care Physician (PCP) was the resident's attending physician while he was hospitalized. The LPN stated that on January 13, 2008 (6 days after his discharge) the PCP came to the facility to assess the	I 401	This Statute will be met as evidenced by: a. Reference response to W 322 a	2.28.08 ongoing

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I 401	Continued From page 6 resident; however, there was no evidence of his assessment. b) On January 16, 2008 between 8:10 AM and 9:18 AM Resident #1's medical and clinical records were reviewed. The records revealed telephone admission orders, dated January 7, 2008. The telephone orders prescribed Resource 2.0 (one can daily at 7:00 AM, 11:00 AM, 4:00 PM and 8:00 PM). The records also revealed a "Nutritional Re-admission Evaluation" dated January 8, 2008. The evaluation recommended that Resident #1's gastric tube feedings be increased to Resource 2.0, five cans daily at 7:00 AM, 11:00 AM, 4:00 PM, 8:00 PM and 12:00 midnight. Transcribed on the resident's Medication Administration Record (MAR) was Resource 2.0 (five cans daily at 7:00 AM, 11:00 AM, 4:00 PM, 8:00 PM and 12:00 midnight). The LPN, interviewed on January 9, 2008 at approximately 9:19 AM, acknowledged that the resident started on Resource 2.0, five cans daily at 7:00 AM, 11:00 AM, 4:00 PM, 8:00 PM and 12:00 midnight on January 9, 2008 at 4:00 PM. Although the LPN alleged that the Primary Care Physician (PCP) was aware of the added can of Resource, he did not change his order on the physician's order sheet (POS). There was no documented evidence that the PCP addressed the nutritionist's recommendation that Resident #1's gastric tube feedings be increased to Resource 2.0, five cans daily at 7:00 AM, 11:00 AM, 4:00 PM, 8:00 PM and 12:00 midnight. c) On January 16, 2008 between 8:11 AM and 9:21 AM Resident #1's medical and clinical records were reviewed. The records revealed telephone admission orders, dated January 7,	I 401	b, c & d Reference response to W 322 b, c & d	

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I 401	Continued From page 7 2008. The telephone orders prescribed an order to flush gastric tube with 30-60 ml. of water before and after each medication pass. Review of the Nutritional Readmission Evaluation dated January 8, 2008 revealed a recommendation to increase water flushes to 200cc after each feeding. The resident's MAR indicated that the nurse started flushing the gastric tube with 200cc of water on January 9, 2008 at 4:00. The facility's LPN, interviewed on January 9, 2008, at approximately 9:22, acknowledged that the nursing staff was following the nutritionist recommendation to flush with 200cc water after each feeding. Although the LPN alleged that the Primary Care Physician (PCP) was aware of the nutritionist recommendation, the physician did not revise his orders reflect the increased to 200cc. d) On January 16, 2008 between 8:11 AM and 9:23 AM Resident #1's medical and clinical records were reviewed. The records revealed telephone admission orders, dated January 7, 2008. The telephone orders prescribed Prosource 30 ml (daily mixed with 30 ml of water via gastric tube). Review of the Nutritional Readmission Evaluation dated January 8, 2008 revealed a recommendation for one scoop of Prosource Protein Powder three times a day, mixed with 30 ml of water via gastric tube. The resident's January 9, 2008 MAR indicated that the nurse started administering one scoop of Prosource Protein Powder three times a day instead of once a day as ordered by the physician. The LPN, interviewed on January 9, 2008 at approximately 9:24 AM, acknowledged that Resident #1 was being administered Prosource Protein Powder three times a day. According to the LPN, the PCP was aware of the nutritionist recommendations but did not make any changes to his order.	I 401		

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I 401	Continued From page 8 e) Review of Resident#1's hospital Discharge Summary dated January 7, 2008 on January 16, 2008 at approximately 8:12 AM revealed that Resident #1's discharge medications included Lovenox 40 mg subcutaneously every day. This medication was used as a prophylaxis while in the hospital. The LPN, interviewed on January 16, 2008 at approximately 8:30 AM, acknowledged that the PCP did not order or addressed the hospital's recommendation for the Resident #1 to receive Lovenox 40 mg. subcutaneously every day. f) Review of the LPN's nursing notes, dated January 7, 2007 at 4:00 PM revealed the following description of Resident #1's pressure ulcers: Two Stage II pressure areas on the right hip measuring 3 x 4 cm; Stage II pressure areas bi-laterally on the right wrist spreading up the arm towards the elbow measuring 3 x 4 cm on the inner aspect of the wrist and 11 x 3 cm on the outer aspect of the wrist; Stage I pressure area on the left hip; Five Stage I pressure areas on the left side of the back measuring 2 x 2 cm; Stage II pressure areas on the left side of left foot near the little toe measuring 2 x 2 cm; Stage I and Stage II pressure areas on the left heel; Stage I pressure on left knee;	I 401	e. Reference response to W 322 e f. Reference response to W 339 & W 322	2.28.08 ongoing

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I 401	Continued From page 9 Stage I pressure ulcer on left buttocks and Stage I pressure area on the left hip. Review of the physician's re-admission telephone orders dated January 7, 2008, on January 16, 2008 at approximately 8:15 AM revealed that Resident #1 had an order for "hydrocolloid wound dressing over pressure areas". Further review revealed that the dressing was to be changed every three days and PRN (when ever necessary). The facility's Licensed Practical Nurse (LPN), interviewed on January 16, 2008 at approximately 8:30 AM acknowledged that primary care physician did not specify the specific pressure areas for the application of the hydrocolloid wound dressing treatment in his telephone order. Additional the nurse failed to clarify the order. Review of the physician's telephone orders dated January 14, 2008, on January 16, 2008 at approximately 8:07 AM revealed that Resident #1 had an order for "curasol gel to all healthy tissue to promote healing". In an interview with the LPN on January 16, 2008 at approximately 8:40 AM it was acknowledged that Resident #1's physician's telephone orders did not specify the specific healthy tissue site (s) to apply the curasol gel treatment. There was no evidence that the physician's telephone orders specified the specific healthy tissue site (s) for the application of the curasol gel treatment. Additional the nurse failed to clarify the order.	I 401		
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire	I 420	1420	

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I 420	Continued From page 10 and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Surveyor: 19076 Based on observation, interview and record review, the GHMRP failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum levels of physical, mental and social functioning for one of one resident in the investigation. (Resident #1) The findings include: 1. Cross Refer to W322.1. The QMRP failed to coordinate services with the Interdisciplinary Team (IDT) to ensure that Resident #1's Health Management Care Plan (HMCP) recommendation for a pressure mattress was addressed as evidenced by: On January 16, 2008, at approximately 7:40AM Resident #1 was observed lying in bed on his left side. Further observation revealed that Resident #1 did not have a pressure on his bed. In an interview with the Licensed Practical Nurse (LPN) on January 16, 2008 at approximately 8:10 AM it was acknowledged that Resident #1 did not have a pressure on his bed. Review of Resident #1's HMCP updated on January 7, 2007, on January 16, 2008, at approximately 8:00AM recommended a pressure mattress for the client's bed to assist in preserving skin integrity. Review of the nursing progress notes dated January 7,	I 420	This Statute will be met as evidenced by: 1. Reference response to W 322.1	2.16.08 ongoing

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I 420	Continued From page 11 2008, on January 16, 2008 at approximately 8:15 AM revealed Resident #1 had multiple decuitus ulcers on his hips, bi-laterally right wrist, back, left foot, left heel, left buttocks and left knee ranging from Stage I to Stage II. There was no evidence that the resident had a pressure mattress on his bed as recommended by the HMCP.	I 420		
I 473	3522.4 MEDICATIONS The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician. This Statute is not met as evidenced by: Surveyor: 19076 Based on staff interview and record review, the facility failed to ensure that any irregularities in the drug regimen for one of one resident in the investigation was reported to the prescribing physician. (Resident #1) The finding includes: Review of the LPN's nursing notes, dated January 7, 2007 at 4:00 PM revealed the following description of Client #1's pressure ulcers: Two Stage II pressure areas on the right hip measuring 3 x 4 cm; Stage II pressure areas bi-laterally on the right wrist spreading up the arm towards the elbow measuring 3 x 4 cm on the inner aspect of the wrist and 11 x 3 cm on the outer aspect of the wrist; Stage I pressure area on the left hip;	I 473	1473 3522.4. This Statute will be met as evidenced by. Reference response to W 339.1	2.28.08 ongoing

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I 473	Continued From page 12 Five Stage I pressure areas on the left side of the back measuring 2 x 2 cm; Stage II pressure areas on the left side of left foot near the little toe measuring 2 x 2 cm; Stage I and Stage II pressure areas on the left heel; Stage I pressure on left knee; Stage I pressure ulcer on left buttocks and Stage I pressure area on the left hip. Review of the physician's re-admission telephone orders dated January 7, 2008, on January 16, 2008 at approximately 8:15 AM revealed that Client #1 had an order for "hydrocolloid wound dressing over pressure areas". Further review revealed that the dressing was to be changed every three days and PRN (when ever necessary). The facility's Licensed Practical Nurse (LPN), interviewed on January 16, 2008 at approximately 8:30 AM acknowledged that primary care physician did not specify the specific pressure areas for the application of the hydrocolloid wound dressing treatment in his telephone order. Additional the nurse failed to clarify the order. Review of the physician's telephone orders dated January 14, 2008, on January 16, 2008 at approximately 8:07 AM revealed that Client #1 had an order for "curasol gel to all healthy tissue to promote healing". In an interview with the LPN on January 16, 2008 at approximately 8:40 AM it was acknowledged that Client #1's physician's telephone orders did not specify the specific	I 473		

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I 473	Continued From page 13 healthy tissue site (s) to apply the curasol gel treatment There was no evidence that the physician's telephone orders specified the specific healthy tissue site (s) for the application of the curasol gel treatment. Additional the nurse failed to clarify the order.	I 473		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Surveyor: 19076 Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to observe and protect the rights of a resident, in accordance with D.C. Law 2-137 (now Title 7, Chapter 13), and this chapter. The finding include: Section 7-1305.05 (g). [Formerly 6-1965] The facility failed to ensure the resident's right to receive prompt and adequate medical attention. A. Review of the physician's orders sheet (POS) on January 16, 2008 at approximately 8:10 AM revealed that Resident #1 had verbal telephone orders that had not been signed by the Primary Care Physician (PCP) with-in twenty- four (24) hours as evidenced below: 1. January 7, 2008:	I 500	This Statute will be met as evidenced by:	

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I 500	Continued From page 14 -Primidone 250 mg one tablet via gastric tube every eight hours; - Keppra 750 mg one tablet via gastric tube every twelve hours; -Iron Sulfate 325 mg tablet twice a day via gastric tube; - Catapres 0.3 mg one tablet via gastric tube twice a day (hold for systolic pressure of less 110); -Colace liquid 25mg (100ml.) via gastric tube twice a day; -Mupirocin ointment 2% twice a day apply to lesions; -Lasix solution 4 ml. (40mg) via gastric tube daily; -Muliti-vitamin tablet one via gastric tube; -Tylenol solution 20.3 ml (650 mg) via gastric tube every six hours PRN (when ever necessary) and - Fleets enema one rectally PRN if no bowel movement in two days. 2. January 9, 2008: - Discontinue Muliti-vitamin tablet one via gastric tube and start Stress formula with Zinc one tablet via gastric tube ; 3. January 14, 2008:	I 500	A. 1. Keppra 750mg & Colace liquid 5ml & Catapress 0.3mg were started on 1/7/08. They were available. Primidone 250mg, Iron Sulfate, Mupirocin ointment, Lasix 40mg, Multivitamin tablet were all administered within 24 hours of admission. Tylenol and Fleet enema are PRN medications. RN will continue to conduct routine file reviews provide direction and feedback to all nurses as needed. RN will implement disciplinary action as warranted. 2. Multivitamin discontinued on 1/9/08 last dose given on 1/9/08 at 8 am. New order on 1/9/08 for Stress Formula w/ Zinc 1 tab daily per g-tube was started on 1/10/08 at 8 am.	1/7/08 and Ongoing 1/9/08 and ongoing

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I 500	Continued From page 15 - Accuzyme ointment to necrotic wound on right forearm and wrist to debride eschar and -Curasol gel to all healthy tissue to promote healing. Review of Resident #1's hospital Discharge Summary dated January 7, 2008 on January 16, 2008 at approximately 8:12 AM. revealed that Resident #1 was admitted to the hospital on December 12, 2007 with admitting diagnoses of seizure disorder and UTI. Resident #1's discharge diagnoses on January 7, 2008 included anemia, Bullous disease and alterations in fluids,electrolytes and nutrition. In an interview with the Licensed Practical Nurse (LPN) on January 16, 2008 at approximately 10:00 AM it was acknowledged that the PCP had not signed his verbal telephone orders with-in twenty- four (24) hours on January 7, 2008, January 9, 2008 and January 14, 2008. There was no documented evidence that the PCP had signed the verbal telephone orders with-in twenty- four (24) hours. B. Resident #1 was admitted to a local hospital on December 12, 2007 with admitting diagnoses of seizure disorder and urinary tract infection (UTI). The resident was discharged on January 7, 2008 with diagnoses of seizure disorder, Urinary Tract Infection (UTI), anemia, Bullous disease, and alterations in fluids, electrolytes and nutrition. The physician failed to ensure that Resident #1 received appropriate quality care after his return from the hospital as evidenced by the following: a) Interview with the Licensed Practical Nurse (LPN) on January 16, 2008 at approximately 8:50	I 500	3. The Accuzyme Ointment was initiated on 1/16/08 as soon as the treatment arrived at the facility. The nursing staff will ensure that there will be no delay in the administration of medication, treatment or service to the client. Also reference response to W 104. B. Reference response to W 322 a	1/16/08 and Ongoing 2.28.08 ongoing

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I 500	Continued From page 16 AM revealed that the Primary Care Physician (PCP) was the resident's attending physician while he was hospitalized. The LPN stated that on January 13, 2008 (6 days after his discharge) the PCP came to the facility to assess the client; however, there was no evidence of his assessment.	I 500		